Basic Health *Plus* Application

Questions? Call 1-800-660-9840

Note: Children enrolled in Basic Health *Plus* must use the same health plan as other family members on Basic Health.

Complete this information for each family member. Make a copy of this form if you need more room.			Gender	Does dependent live in your home?	Relationship to you	U.S. citizen?	Applying for Basic Health *Plus*?
Subscriber's name	Social security number	Birth date	❑ M ❑ F			❑ Yes ❑ No	❑ Yes ❑ No
Subscriber's employer		Employer's address					
Spouse's name (must be legally married)	Social security number	Birth date	❑ M ❑ F			❑ Yes ❑ No	❑ Yes ❑ No
Spouse's employer		Employer's address					
Dependent	Social security number	Birth date	❑ M ❑ F	❑ Yes ❑ No	❑ Son ❑ Daughter ❑ Other	❑ Yes ❑ No	❑ Yes ❑ No
Dependent	Social security number	Birth date	❑ M ❑ F	❑ Yes ❑ No	❑ Son ❑ Daughter ❑ Other	❑ Yes ❑ No	❑ Yes ❑ No
Dependent	Social security number	Birth date	❑ M ❑ F	❑ Yes ❑ No	❑ Son ❑ Daughter ❑ Other	❑ Yes ❑ No	❑ Yes ❑ No
Dependent	Social security number	Birth date	❑ M ❑ F	❑ Yes ❑ No	❑ Son ❑ Daughter ❑ Other	❑ Yes ❑ No	❑ Yes ❑ No

1. Have you checked "no" to "U.S. citizen" for any family member applying for Basic Health *Plus*? ❑ Yes ❑ No
   If yes, please provide a copy (front and back) of that person's INS documentation, and indicate their date of arrival into the U.S. ______________________________

2. What was the amount of your gross (before taxes) household income for the most recent full calendar month? $ ____________________
   You must send proof of your household income for the most recent full calendar month (copies of pay stubs, unemployment insurance, child support, etc.).
   What days were you paid on during that month? ______________________________
   If you are self-employed or have rental income, please complete the *DSHS Programs' Self-Employment or Rental Income Worksheet*, included in this packet, and supply copies of your receipts and expenses for the most recent calendar month (do not give yearly totals). If you have had no income in the last 30 days, attach a signed and dated note telling us how you support yourself.

3. Do you pay court-ordered support? ❑ Yes ❑ No
   If yes, how much do you pay each month? ______________________________
   You must provide proof, such as a court order, of what you pay each month.

4. Are you applying for Basic Health *Plus* coverage for a child whose other biological parent is not married to you, but is living in your home? ❑ Yes ❑ No
   If yes, you must fill in the information about that parent below, and attach proof of that person's monthly income.

5. Home phone number: (   ) ____________________ Other phone number: (   ) ____________________

7. Have you had a recent change in address: ❑ Yes ❑ No

If yes, please write your current address: _____

8. List yourself and any family members who have other health insurance or are covered under a health program such as Tri-Care, Medicare, or Medicaid.

Last name	First name	M.I.	Health insurance company or health program	Phone number of health insurance company or program	Policy or group number	Policy end date
(List yourself first.) 1.				( )		/ /
2.				( )		/ /
3.				( )		/ /

9. Completing this information is voluntary and will not affect your ability to enroll in Basic Health *Plus*.

Please indicate your ethnic background:

❑ Black/African-American ❑ White/Caucasian ❑ Indian (Native American)
❑ Eskimo ❑ Aleutian Islander/Aleut ❑ Asian or Pacific Islander (API)
❑ Hispanic/Latin American ❑ Other or mixed ethnic background

Do you need an interpreter? ❑ Yes ❑ No

If yes, what language and dialect do you speak? _____

10. Are you applying for Basic Health coverage for a child with an urgent medical need? ❑ Yes ❑ No

If yes, give the child's name here: _____

11. Do you have any unpaid medical bills, or have you received medical services in the past three months for any of the children above (Basic Health *Plus* applicants) that are NOT covered by other insurance? ❑ Yes ❑ No
If yes, attach proof of income for those three months.

12. If you need help in a language other than English, what language and dialect do you speak?

_____

AGREEMENT AND SIGNATURE

I understand that:

- I must provide proof of my gross family income (before taxes and deductions) and report income changes that would change my premium or eligibility to Basic Health/Department of Social and Health Services (DSHS) within 30 days after the end of the month my income changed.
- By signing this form, I have authorized Basic Health and DSHS to verify my eligibility information and family income with other state or federal agencies or other third-party sources.
- I must report address changes and changes in my family. I must report, for example, my marriage or divorce, or the marriage or divorce of any family member on my account, the birth or adoption of a child, or the date when a child leaves home or is no longer a dependent or is no longer a full-time student.
- My application and the documents I send to Basic Health will be used to determine eligibility for DSHS programs (Basic Health *Plus* or the Maternity Benefits Program).
- By asking for and receiving DSHS benefits, my family and I assign to the state of Washington our rights to any third-party payment for medical care of covered medical services while receiving medical benefits.
- Basic Health's deposit of my premium payment does not guarantee coverage. The payment will be refunded if I am determined ineligible for coverage.

I authorize my health plan or medical provider to give medical records for me or my children to Basic Health, for purposes of participation in Basic Health/DSHS programs.

I have read and I understand the information provided to me with the Basic Health application. I declare, under penalty of perjury, that the information I have given in this application and the documents I send to Basic Health are true, correct, and complete to the best of my knowledge. I understand that if I or any member of my family, or any person on my behalf, submits false information, my family or I may lose coverage, may be held financially responsible for services obtained under Basic Health or additional premium amounts due, and may face other penalties and prosecution. Any debt owed to the state may be sent to a collection agency for recovery.

_____ _____

Signature of parent or guardian Date

DSHS Programs' Self-Employment or Rental Income Worksheet

Complete this form in addition to other applicable forms.

- **For this form, report the dollar amounts of your most current complete calendar month. Do not total and do not transfer this page to the *Family Income Reporting Form*. This form is to help DSHS determine your eligibility for Basic Health *Plus*.**
- **You must provide proof of all your gross receipts and expenses for the last complete calendar month.**
- **If you are requesting DSHS help with unpaid medical bills from the last three months, you must copy and complete this form for each of those months.**

Applicant's name: _____ Month of: _____

1. Name of business:	Type of business:
2. Business street address:	

❑ PARTNERSHIP ❑ INCORPORATED ❑ SOLE PROPRIETORSHIP

For partnerships and corporations, list members' names and relationships: _____

_____

If incorporated, monthly amount paid to you by corporation: $_____

Check and complete if no longer self-employed.

❑ I am no longer self-employed Date of last pay: _____

Last day worked: _____ Amount of last pay: $ _____

YOU MUST PROVIDE PROOF FOR ALL INCOME AND EXPENSES LISTED BELOW.

Gross business income (month of report only)	$
Employees (not including yourself, your spouse, or your children): _____	
Wages and commissions paid in month of report	$
Employer share of social security taxes paid in month of report	$
Business expenses (month of report only)	
Printing	$
Postage/shipping	$
Supplies/materials	$
Advertising/accounting	$
Insurance (business-related only)	$
Business licenses, trade dues, etc.	$
Business loan (interest paid only)	$
Business tax (sales, UI, L&I, B&O, etc.)	$
Other (list and describe):	
	$
	$
	$
	$

DSHS WILL TOTAL ALLOWABLE EXPENSES.

Business location	
Is business in your home?	❑ Yes ❑ No
If yes, is the room/area used for business purposes **only?**	❑ Yes ❑ No
If yes: Total square footage in your home:	
Square footage used for business:	
Rent (for business address or home business only)	$
Mortgage	$
Utilities (including telephone, electricity, water, etc.)	$
Business transportation costs	
Is your vehicle used for business only?	❑ Yes ❑ No
Total miles driven for month of report:	
Total miles driven **on the job** for month of report:	
Vehicle repairs for vehicle used for business (paid in month of report only)	$
Registration and license fees for vehicle used for business (paid in month of report only)	$
Interest only from payments on vehicles used for business (paid in month of report only)	$
Check and complete **one:** ❑ I want to deduct $.485 per mile for gas, oil, and fluids ❑ I want to deduct actual expenses for gas, oil, and fluids	$

Basic Health™

Complete and return this form. See back for additional instructions.

Family Income Reporting Form

Basic Health I.D. # (usually your social security number) _____

Have you changed employers in the last 12 months? ❑ Yes ❑ No Has your income changed in the last 12 months? ❑ Yes ❑ No

Briefly explain change(s) _____

Basic Health may average or use your last 30 days' income to get the most accurate picture of your income.			
You **must** check "yes" or "no" for each family member on every income line item. Show gross amounts. If more dependents, list on a separate sheet or copy this form.	**Self**	**Spouse**	**Child**
Wages, salary, tips, assistantships, commissions Employer name (self) _____ Employer name (spouse) _____	❑ Yes ❑ No $	❑ Yes ❑ No $	
Self-employment or rental income Provide Washington State Unified Business Identifier (UBI) # _____ Check box if no UBI # ❑ (For details on what to send us, see the back of this form.)	❑ Yes ❑ No $	❑ Yes ❑ No $	❑ Yes ❑ No $
Unemployment compensation, strike benefits	❑ Yes ❑ No $	❑ Yes ❑ No $	
Social security benefits - circle types received Retirement Survivor Supplemental security (SSI) Disability If social security disability, date of entitlement _____	❑ Yes ❑ No $	❑ Yes ❑ No $	❑ Yes ❑ No $
Retirements, pensions, annuity benefits Is the amount received due to an early withdrawal? ❑ Yes ❑ No	❑ Yes ❑ No $	❑ Yes ❑ No $	❑ Yes ❑ No $
Child support, alimony/spousal maintenance	❑ Yes ❑ No $	❑ Yes ❑ No $	❑ Yes ❑ No $
Insurance benefits, whether private or through employment, such as life, accident, long- or short-term disability	❑ Yes ❑ No $	❑ Yes ❑ No $	❑ Yes ❑ No $
Interest, dividends, trust, estate, inheritance, capital gains, gambling, lottery, royalties	❑ Yes ❑ No $	❑ Yes ❑ No $	❑ Yes ❑ No $
Veterans' benefits, military allotments	❑ Yes ❑ No $	❑ Yes ❑ No $	❑ Yes ❑ No $
Workers' compensation, crime victims' compensation	❑ Yes ❑ No $	❑ Yes ❑ No $	❑ Yes ❑ No $
Public assistance cash grants **DO NOT INCLUDE FOOD STAMPS**	❑ Yes ❑ No $	❑ Yes ❑ No $	❑ Yes ❑ No $
Income from any other source Explain _____	❑ Yes ❑ No $	❑ Yes ❑ No $	❑ Yes ❑ No $
No income from any source If both you and your spouse report no income, how do you support yourselves? _____	❑ No income	❑ No income	

Must be signed by both you and your spouse, if married

_____
Your printed name Your signature Date

_____
Spouse's printed name Spouse's signature Date

Privacy statement: Washington State law may require disclosure of any information you submit as a public record. Basic Health is administered by the Health Care Authority (HCA); our Privacy Notice is available upon request by calling 360-923-2822 or online at **www.hca.wa.gov**.

Explanation of income types and what to send with your *Family Income Reporting Form*

Current documentation from the Internal Revenue Service (IRS) is required if not already on file with Basic Health:

- Your IRS Form 1040, federal income tax form, and all schedules
- Schedule K-1 for each family member for each S-Corporation, partnership, or trust beneficiary
- A complete IRS transcript, if you do not have a copy of your IRS Form 1040
- Verification of non-filing status from the IRS if you did not file a tax return

To request a transcript or letter of non-filing status, call the IRS at 1-800-829-1040.

Income documentation must include the name of the person paid, the **gross** amount(s) paid, and the dates paid. Send a full 30 days' documentation for each income source. On a separate sheet, explain any gaps in income. **(Always send current documents.)** If you need another copy of this form, or would like more information about Basic Health, visit our Web site (**www.basichealth.hca.wa.gov**).

Do not mail originals to Basic Health; they will not be returned to you.

Explanation of income type	Examples of copies you might send
Wages, salary, tips, assistantships, commissions	• Pay stubs • Signed and dated statement from employer(s)
Self-employment or rental income	• IRS 1040 and all applicable schedules • K-1(s), if applicable • *DSHS Programs' Self-Employment or Rental Income Worksheet* • Statement of income and expenses (any business not shown on 1040) • Washington State Unified Business Identifier (UBI) number
Unemployment compensation, strike benefits	• Unemployment stubs • Strike benefit statement • Computer print-out from agency/payer
Social security benefits	• Initial notice of award letter • Statement showing monthly benefit amount • Computer print-out from agency/payer
Retirements, pensions, annuity benefits	• Award letter or benefit statement • Cost of living allotment statement • Signed and dated statement from payer(s) • Computer print-out from agency/payer
Child support, alimony/spousal maintenance	• Award letter • Court documents or Division of Child Support (DCS) statement • Signed and dated statement from payer(s) • Computer print-out from agency/payer • Copy of check
Insurance benefits	• Award letter • Court documents • Statement from institution
Interest, dividends, trust, estate, inheritance, capital gains, gambling, lottery, royalties	• IRS 1040 and all applicable schedules • Statement from trustee, investment firm, bank, or financial institution • Court documents • Copy of contract • Copy of check
Veterans' benefits, military allotments	• Award letter or benefit statement • Leave and Earnings Statement (LES)
Workers' compensation, crime victims' compensation	• Award letter or benefit statement • Labor & Industries (L & I) payment order
Public assistance cash grants	• Award letter or benefit statement • Computer print-out from Department of Social and Health Services (DSHS)
Income from any other source	• Signed and dated statement from payer • Signed and dated statement from applicant/member
Personal care workers, independent providers	• Social Service Payment System (SSPS) invoice, **and** • Remittance Advice, pages 1 and 2

Can dependent care expenses be deducted?

Yes; you may deduct work- or school-related dependent care expenses (work- or school-related means the dependent spends time in dependent care so that adults in the home can go to work or school). You must provide copies of receipts that include the amount you paid, the dates of care, and the dependent care provider's name, address, and phone number.